

proper care, and should be resorted to more often than is at this date sanctioned by general surgical opinion.

2. The best incision is the transverse, below the twelfth rib, with as much of a liberating incision downward along the line of the edge of the quadratus as may be required to gain ample room.

3. The kidney may be freely cut into and rudely lacerated with the finger, when the stone calls for it, without producing any hæmorrhage which hot irrigation will not control.

4. It is better, in the case of a large branching calculus, to break it up and extract it in fragments, rather than to attempt to remove it entire.

5. So little danger attaches to the posterior incision that it seems wiser always to make it the first step, reserving peritoneal exploration for a later resource in cases where the posterior exploration miscarries. —*Med. Record*, February 8, 1890.

**II. Extirpation of Tuberculous Seminal Vesicles** By Dr. EMERICH ULLMANN (Vienna). In 1829, Dalmar described a chronic inflammation of the seminal vesicles, the description of which corresponds closely to that of tuberculosis. Since then the affection has been described by Albers, Jaye, Naumann, Humphrey and Kocher, and lately it has been studied by Rayer, Cruveilhier and Reclus, as secondary to tuberculosis of the lungs.

As a secondary affection, this trouble is not only seen in connection with tuberculosis of the lungs, but is more common after primary tuberculosis of the epididymis, either as a continuation of the cheesy degeneration in the vas deferens, or spreading by contiguity of tissue from the sides of the prostate.

Primary tuberculosis of these organs is extremely rare, and still less often diagnosed, and up to the present time no surgical interference has been attempted.

Ullmann gives the history of a case where he removed the seminal vesicles. It is as follows:

Boy, æt. 17 years, entered the clinic with right sided tubercular testicle; the seminal vesicles on that side were much enlarged. Left side

normal, lungs apparently healthy, sexual functions not yet developed, no erections, no emissions.

On July 17, 1889, unilateral castration on right side.

July 27. Extirpation of right seminal vesicles by a semilunar incision of the perineum, midway between scrotum and anus, the base of the incision being directed toward the sacrum; a careful dissection of the tissues was made and the prostate reached. The rectum was dissected away from this organ, and the posterior wall of the bladder made to protrude slightly by means of a sound introduced through the urethra, so that the vasa deferentia and the seminal vesicles could be distinctly seen. The right seminal vesicle was much enlarged, and its upper part cheesy, its lower part much infiltrated, as well as the vas deferens on that side. The left vesicle was enlarged and hardened. These parts were carefully dissected away and the left vas deferens left in place. In the right upper corner of the prostate a small abscess was found, and this part of the gland was removed. The hæmorrhage being checked, a drainage tube was introduced in the wound, which was then closed by sutures. That evening a severe secondary hæmorrhage took place, which required reopening of the wound, and its packing with iodoform gauze. Some urine escaped through the wound, showing that the bladder had been opened. The patient recovered from the effects of this operation in a very short time, and gained flesh and strength. The wound closed perfectly, except for a small fistula, and all the urine is voided through the urethra. Lately he says he has had two erections. Microscopical examination of the removed part showed plenty of tubercle bacilli. Dr. Ullmann recommends this operation in the following cases:

1. In primary tuberculosis of the testicle or epididymis, when no suspicious symptoms have appeared on the sound side, and when on the affected side the vesiculæ seminales are already attacked. (Should both vesicles be diseased and one vas deferens healthy, the latter should be left undisturbed, but the vesicles removed.)

2. In cases of primary tuberculosis of the seminal vesicles.

The impotence following the operation should be no contra-indication, for in all reported cases of tuberculosis of the seminal vesicles,

impotence always occurs in a short time; in fact it is regarded as a cardinal symptom of the disease.—*Centralbl. f. Chir.*, No. 8, 1890.

F. C. HUSON (New York).

## WOUNDS, INJURIES, ACCIDENTS.

**1. Accidents Following the Sojourn of Projectiles in the Tissues.** By Prof. J. CHAUVEL (Paris). In a paper read before the Academy of Medicine of Paris in October, 1887, M. Chauvel held that in those regions of the body where perfect asepsis was difficult or impossible, the general rule now admitted of non-intervention after the lodgement of projectiles should not be observed. Lately he has had to operate on three cases in which the projectile imbedded in the tissues gave rise to very serious symptoms. His cases were:

1. Gunshot wound of right thigh; extraction four months later of the projectile (a piece of iron), which kept up a profuse suppuration, and interfered with the movements of the limb; perfect cure followed the removal of the foreign body.

2. Bullet wound of left knee-joint in 1870, followed by ankylosis at right angles; track of bullet never completely closed, persisting fistulæ, osteitis. Amputation of thigh for relief of symptoms done in 1889. Bullet found lodged in internal condyle.

3. Bullet wound of left hip in 1884, persisting fistulæ and neuralgic pains ever since injury; extraction of a sequestrum from the ilium. The bullet still remains in the pelvis, and the patient is only improved. The doctor, after carefully describing and analyzing the above cases, comes to the following conclusions:

1. Tolerance of bullets is not as common as is generally believed, and is the exception rather than the rule.

2. That immediate extraction of the projectile must not be abandoned, provided the operation is easy and not too dangerous.

3. The accidents following the lodgment of a bullet in the tissues vary according to the nature of the tissues and the seat of the projectile, and often, instead of improving with time, they grow worse.

4. When this is the case surgical intervention is necessary, and the